Health History

- 1. Define health and health assessment
 - Health: a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity
 - b. Health assessment: health history gather data from the patient/or family, past medical records, physical and psychological issues, social and cultural associations, environment, developmental level, and spiritual beliefs contributes to the history. Purpose: determine a patient's health status, risk factors, and need for education as a basis for developing a nursing plan of care
- 2. Differentiate between sign/symptom, subjective/ objective data
 - Sign is objective, what the practitioner observes. (color of skin, nails bed, mass on abdomen)
 - b. Symptom is subjective, what the patient reports (pain, headache)
- Understand and demonstrate when to use open vs closed ended questions
 - a. Open the interview with a broad, open-ended question
 - b. End interview with close-ended questions (think cone)
- 4. Explain the components of the health assessment
 - a. Health history interview
 - b. Physical exam
 - Purpose: determine a patient's health status, risk factors, and need for education as a basic for developing a nursing plan of care
 - d. Structure/order of the history:
 - The identifiers: name, date, age, time, gender, race, occupation, referral source, marital status, relationship status
 - ii. Chief complaint
 - iii. History of present illness
 - OLDCART
 - iv. Past medical history
 - Adult medical illness, surgery-procedures, childhood illnesses, trauma, more recent PE-screening. Last menstrual period, meds, allergies, transfusions, emotional status
 - v. Family history
 - vi. Personal and social history personal status, habits, sexual history, home conditions, occupation, environment, military record, religious preference, access to care, sleep pattern, exercise, living situation, work environment/occupational history, relaxation, hobbies, nutrition, tobacco (PPD).

Health Assessment Study Guide Questions

Ian Pickup

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